	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O	R; (X2) M	ULTIPLE CONSTRUCTION /	(X3) DATE SURVEY COMPLETED
		445260	B, WIN	IG	10/28/201
	PROVIDER OR SUPPLIER CLIFF HEALTH CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 100 ELMHURST DR OAK RIDGE, TN 37830	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMP
, , , , , , , , , , , , , , , , , , ,	A facility must use to develop, review a comprehensive plan. The facility must develop for each reside objectives and timet medical, nursing, an needs that are identical assessment. The care plan must to be furnished to atthe furnished to atthe findings and any seep to the required under §4 due to the resident's §483.10, including the under §483.10, including the under §483.10 (b)(4). This REQUIREMENT by: Based on medical recand interview, the facility and include fall prefersident (#6) of twenty. The findings included: Resident #6 was admit	he results of the assessind revise the resident's of care. Velop a comprehensive on that includes measurables to meet a resident of mental and psychosocified in the comprehensive describe the services that ain or maintain the resident or maintai	are ble s ial re it are ent's se ed it d are e	This Plan of Correction is proposed and executed because it is respectively the provisions of State and Eederal Law, and not because Briarcliff Healthcare Facility with allegation(s) and citation listed on this Statement of Deficiencies. Briarcliff Health Facility maintains that the allegation deficiencies do not Individual collectively constitute substacare or jeopardize the health safety of the residents; nor an of such character so as to limic capability to render adequate. This Plan of Correction shall serve as the facility's written Allegation of Compliance. F-279 A fall risk assessment was compliance. F-279 A fall risk assessment was compliance. F-279 A fall risk assessment was compliance. The Risk Manager reviewed all regular bed in the lowest position care plans accurately reflect the measures. Resident #6 has not incidents/accidents since 06/19/10. The Risk Manager reviewed all F. Assessments, Incident Reports, and Care Plans for the time fram 06/19/10 through 10/28/10 and didentify any other residents. All incidents/accidents will be reviewed by the Interdisciplinary Team dail	equired ad eagrees (s) hcare eged lly or undard and re they alt our care. also Credible 12-12-10 pleted in a m. The current had any 10. Fall Risk MDS, e of id not leewed by to
9	3, 2009, with diagnose Schizophrenia, Multipl Sastrostomy.	s including Paranoid		ensure appropriate Interventions recommended, put Into place and resident's care plans are updated reflect all changes.	l the

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencles are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: B99311

Facility ID: TN0101

		AND HIMAN SERVICES				PRINTE	D: 11/02/2010
	RS FOR MEDICARE					OMB NO	M APPROVED D. 0938-0391
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CO	NSTRUCTION	(X3) DATE COMP	SURVEY
		445260	B, WI	۱G		10/	28/2010
NAME OF I	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE		20/2010
BRIARC	LIFF HEALTH CARE (ENTER		100 ELM	HURST DR DGE, TN 37830		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	X CF	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE
F 279	Continued From page	ge 1	F 2	70			
	Set) dated July 18, 2 had impaired long a moderately impaired assistance with trans	2010, revealed the resident nd short term memory, discognition, required extensive sfers, and had experienced a		The omega months improved the control of the contro	corrective action will be mon hly in the Continuous Quality overnent meeting comprised ADON, Risk_Manager, Mon	y of the lical	
	Medical record revieus June 19, 2010, at 4:: was found on the florecord review of the dated June 19, and 2 resident did not have Medical record review June 21, 2010, revea asked to screen pt (pfallen out of bed. No notedRecommend bowl' mattress to premattress/bed." Review of the facility: the fall dated June 19	w of a nursing note dated 50 p.m., revealed the resident or beside the bed. Medical nursing notes and x-rays 20, 2010, revealed the e any injury from the fall. w of a Resident Screen dated aled, "PT (physical therapy) patient) p/ (after) fall. Pt had functional change mattress c/ (with) edges or		Direc	tor, and/or Administrator for ance.	Quality	
M L C C C C C C	Medical record review pdated June 19, Aug Dctober 11, 2010, revesident was to have a the side of the bed. Observation on October 26, 2010, from: 40 p.m., and October 18:35 a.m., revealed	of the resident's care plan rust 2, August 18, and ealed no documentation the a convex mattress or pads er 26, 2010, at 10:55 a.m., m 8:50 a.m., until 9:05 a.m., r 28, 2010, at 8:05 a.m., at the resident lying in bed, no pads to the side of the					

DEPA	RTMENT OF HEALT!	HAND H' "MAN SERVICES	88			PRINTE	D: 11/02/2010
CENT	ERS FOR MEDICARE	& MEL ID SERVICES				FOR OMB N	M APPROVED O. 0938-0391
STATEMI AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		NSTRUCTION	(X3) DATE	
		445260	B. WIN	G		1	laa (a
NAME OF	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE	10	/28/2010
BRIAR	CLIFF HEALTH CARE	CENTER		100 ELM	HURST DR OGE, TN 37830		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 2	F 2	79			+
·······	Interview with CNA October 27, 2010, a 2010, at 8:35 a.m.,	#1 (certified nurse aide) on at 1:15 p.m., and October 28, in the resident's room.			150	8	
	Interview with the ris 2010, at 3:50 p.m., a confirmed the residen mattress in place to Interviews with the Non October 28, 2010 conference room, conot been updated to prevention measures 483.20(k)(3)(i) SERV PROFESSIONAL ST The services provide must meet profession This REQUIREMENT by: Based on medical recand interview, the facing medications according one resident (#6) of the reviewed. The findings included:	CICES PROVIDED MEET ANDARDS d or arranged by the facility hal standards of quality. is not met as evidenced for review, observation, lity failed to administer g to the physician's order for venty-four residents	F 283	Adminimus coorders. The Discomple Record resider There was months Record for discomples 12/12/2 on Med Recond Transcr The commonthly Improve DON, All	rector of Medical Records ated a Medication Administrat audit on 10/31/10 and no oth it's were identified. Will be monthly audits for three of all Medication Administrat is by Medical Records to chec repancies. The Staff ment Coordinator will condu- ervice for all licensed staff by 010 which will consist of train ication Administration Record ilitation and Prevention of iption Errors. rective action will be monitore in the Continuous Quality ment meeting comprised of the DON, Risk Manager, Medical and/or Administrator for Qua	elon her e tion ck ct ing f	12-12-10

CENT	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES - & MEL ID SERVICES			=	FOR	D: 11/02/2010 M APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 0000	MULTIPLE IILDING	CONSTRUCTION	(X3) DATE COMPI	
		445260	B. WI	NG		10/	28/2010
	PROVIDER OR SUPPLIER CLIFF HEALTH CARE (CENTER		100 E	TADDRESS, CITY, STATE, ZIP CODE ELMHURST DR RIDGE, TN 37830		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	Continued From page Schizophrenia, Multi Gastrostomy.		F 2	281		us.ttact	
	order dated June 3.	ew revealed a physician's 2010, for Vitamin D 50,000 IU to be given daily on Monday, idays.				Comment and the Comment and th	
	LPN #1 (Licensed Pithe resident's room, administration. Conf LPN #1 read the MA Record) for the Vitan Wednesday, and Frid medication as given 2010, had been mark not to administer on the standard process.						
	2010, revealed the madministered Monday until October 13, 2011 revealed the medicati Wednesday, October 14 Friday, October 15; w. October 17; was not a October 18; was administered mot administered Tuesday administered Tuesday	y, Wednesday, and Friday, D. Continued review on was not administered 13; was administered it; was not administered as administered Sunday, administered Monday, inistered Wednesday, administered Friday, October Saturday, October 25; and was a Cotober 26.					
5	on October 27, 2010, a station, confirmed the	and the nursing supervisor at 9:05 a.m., at the nursing medication had not been g to the schedule ordered					

DEPA	RTMENT OF HEALTH	AN P	ID HUMAN SERVICES						D: 11/02/2010 M APPROVED
STATEME	ERS FOR MEDICARE NT OF DEFICIENCIES								0.0938-0391
AND PLAN	OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			NSTRUCTION	(X3) DATE COMP	SURVEY
		1	445260	B. WI	NG_			100	0010010
NAME OF	PROVIDER OR SUPPLIER				- T	355T 461		10/	28/2010
BRIAR	CLIFF HEALTH CARE (CENT	TER		1	00 ELMI	DRESS, CITY, STATE, ZIP CODE HURST DR DGE, TN 37830		
(X4) ID	SUMMARY STA	TEME	ENT OF DEFICIENCIES	QI	_				
PREFIX TAG	(EACH DEFICIENCY	MUS	T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PREF		CR.	PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	COMPLETION DATE
F 281	Continued From page	ge 4		E '	281				
	by the physician.	•		F-4	401				1
F 323	483.25(h) FREE OF	AC	CIDENT	F	323	F-323			12-12-10
SS=D	HAZARDS/SUPER	/ISI	ON/DEVICES	"	123	A fall	risk assessment was comple	eted	1.2 .2 .0
						TOT re	sident #6 on 10/27/10. Resid	ent is	4
	The facility must ens	sure	that the resident			positi	ntly in a regular bed in the low on. The care plans accurately	west	
	environment remain	s as	free of accident hazards			reflec	t the current measures Regi	dent	
	as is possible; and a	each	resident receives			#6 ha	s not had any incidents/accid	lents	
	prevent accidents.	n an	d assistance devices to		- 2	SITICE	00/19/10. An Occupational		
	provent accidents.					Resid	py Screen was completed fo ent #9 on 10/18/2010. Resid	Γ	1
						currer	tly receiving Occupational	ent is	
						Thera	by for Range of Motion and		
						Positio	oning. The care plan accurate	∌ly	1
	This REQUIREMEN	T is	not met as evidenced			renect	s the current measures. Res	dont	
	by:					#9 nas	not had any incidents/accid	ents	
	Based on medical re	cord	review, observation,			Sinte (57713710.		
	prevention manager	cility	failed to implement fall			The Ri	sk Manager reviewed all Fall	Riek	
	#9) with a history of	TOF	two residents (#6 and			Assess	Sments, Incident Reports, Mr.	20	
	reviewed.	ans	of twenty-four residents		1	and Ca	are Plans for the time frame	ve.	
,	Triowod,					resider	10 through 10/28/10 and no outs were identified.	other	
	The findings included	l:				rouldy,	were identified.	1	
ĺ					1	All Incid	ents/accidents will be revieu	ved	3
1	Resident #6 was adm	ittec	to the facility on August			by the I	Interdisciplinary Team daily to	0	1
	3, 2009, With diagnosi	es in	icluding Paranoid			recomp	appropriate interventions are	•	
	Schizophrenia, Multip	le S	clerosis, and	£0.		residen	nended, put into place and the t's care plans are updated to	0	1
	Gastrostomy.					reflect a	all changes.	1	- 1
	Medical record review	of t	he MDS (Minimum Data		10.				
1	Set) dated July 18, 20	10 1	revealed the resident			The cor	rective action will be monitor	ed	ŧ
	had impaired long and	isho	ort term memony			Improve	in the Continuous Quality ment meeting comprised of	4.000	
1	moderately impaired o	oani	ition, required extensive			DON, A	DON, Risk Manager, Medica	ine	
	assistance with transfe	ers, a	and had experienced a		1	Director	and/or Administrator for Out	ality	1
	fall within the last 30 d	ays.			1	Assuran	ice.		
1	Medical record review	of a	nursing note dated						
	June 19, 2010, at 4:50	D.m	revealed the resident						1
, ,	vas found on the floor	besi	ide the hed Medical						
	ecord review of the nu	irsin	g notes and x-rays						1

CENTE	RS FOR MEDICARI	E & MEL .ID SERVICES		25000000	49 sT(0)0.55	M APPROVEL D. 0938-0391
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPI	SURVEY
		445260	B. WING		10/	28/2010
	PROVIDER OR SUPPLIER	CENTER	10	ET ADDRESS, CITY, STATE, ZII DELMHURST DR AK RIDGE, TN 37830		26/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	dated June 19, and resident did not have	20, 2010, revealed the real and injury from the fall.	F 323			
	asked to screen pt fallen out of bed. N	ealed, "PT (physical therapy) (patient) p/ (after) fall. Pt had to functional change d mattress c/ (with) edges or revent fall out of				
	the fall dated June side of bed, PT re-s	y's Post-Incident Actions after 19, 2010, revealed, "Pads to creened res (resident), & placed regular mattress."				
	October 26, 2010, fi 3:40 p.m., and Octo and 8:35 a.m., revea with the bedrails down	ober 26, 2010, at 10:55 a.m., rom 8:50 a.m., until 9:05 a.m., ber 28, 2010, at 8:05 a.m., aled the resident lying in bed vn, no pads to the side of the mattress on the bed.				
	October 27, 2010, at 2010, at 8:35 a.m., in confirmed the reside side of the bed, the band the CNA was no	t1 (certified nurse aide) on t1:15 p.m., and October 28, the resident's room, nt did not have pads to the ped had a regular mattress, t aware of the resident ever tress or pads to the side of		20		
l c	27, 2010, at 3:45 p.m confirmed the resider	rsing supervisor on October i., at the nursing station, int did not have the convex if a convex mattress had not resident.				
1	nterview with the risk	manager on October 27,				

PRINTED: 11/02/2010

FORM APPROVED

	RTMENT OF HEALTH	HAND HUMAN SERVICES 8 MED D SERVICES				FORM	APPROVED 0. 0938-0391
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDIN	IPLE CONS	TRUCTION	(X3) DATE COMPI	SURVEY
		445260	B. WING		To the state of th	10/	28/2010
	PROVIDER OR SUPPLIER		1	00 ELMHU	ESS, CITY, STATE, ZIP CODE RST DR IE, TN 37830		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORR ICH CORRECTIVE ACTION S SS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	2010, at 3:50 p.m., confirmed the reside falls and the reside mattress in place-to Resident #9 was re October 28, 2010, v Failure to Thrive, Al Movement, Malaise Fall. Medical record revie September 29, 2010 impaired long and s moderately impaired assistance with tranfall within the last 30 Medical record revie September 5, 2010, "Resident (up) in broactivated & resident side. Resident verbifloor. Denies any disdocumented. Medical record revie Screening of Reside date 9/7/10. Fall dat	at the nursing station, ent had not had any further of was to have the convex opprevent further falls: -admitted to the facility on with diagnoses including conormal Involuntary and Fatigue, and History of ew of the MDS dated of the memory, discognition, required extensive sfers, and had experienced a order. Noted body alarm lying in the floor on (L) (left) alizedslid out of chair into scomfort" and no injury was we of the Rehab Supplemental of the Falls revealed, "Screen to 9/5/10Pt attempted to get	F 323		DEFIGIENCY)		
	safetyOT (occupation Medical record revieus screens completed in been a quarterly scre 2010, and a screen of motion completed Occupation	slid to floorconfused; poor ional therapy) to screen" w revealed the only therapy in the medical record had sen completed August 24, lue to decreased range of ctober 18, 2010. sk manager on October 28,					

	RIMENT OF HEALTH	AND HUMAN SERVICES				FORI	D: 11/02/2010 VI APPROVED D. 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		STRUCTION	(X3) DATE	
		445260	B, WING			10/	28/2010
NAME OF	PROVIDER OR SUPPLIER		s	TREET ADD	RESS, CITY, STATE, ZIP CODE		
BRIARC	LIFF HEALTH CARE	CENTER		100 ELMF	URST DR GE, TN 37830		
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION SHOOT CORRECTIVE ACTION SHOOT COSS-REFERENCED TO THE APPROPRIED TO THE A	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 7	F 32	3			-
	2010, at 9:30 a.m., with the manager of at 9:45 a.m., in the t	at the nursing station, and therapy on October 28, 2010.	1 02				
F 502 SS=D	falls; the resident was therapy screen after 2010, to determine if were needed; and the completed. 483.75(j)(1) PROVID	as to have an occupational the fall on September 5, f any further fall interventions he screen had not been DE/OBTAIN LABORATORY	F 502	2			
	services to meet the	vide or obtain laboratory needs of its residents. The for the quality and timeliness		review	epakote level for resident #1 ed 10/28/10. The results wer ed by the Nurse Practitioner 10 with no new orders.	ra ca	12-12-10
	by: Based on medical re facility failed to obtain resident (#11) of twe The findings included Resident #11 was ad February 16, 2001, w Fractured Femur, Os Disorder, Peripheral Cerebrovascular Acc Medical record review	mitted to the facility on with diagnoses including teoporosis, Dysthymic Vascular Disease, and ident.		The Me comple months labs are timely, during to monthly lmprove DON, A	edial Records Director conducted audit of routine labs and esidents were identified. edical Records Director will the a weekly audit for three on all lab orders to ensure a scheduled and completed Results of audits will be revieweekly Focus meeting. Trective action will be monitor in the Continuous Quality ement meeting comprised of DON, Risk Manager, Medical, and/or Administrator for Quice.	d no all ewed ed the	

Medical record review of the laboratory data revealed no Depakote lab results for July 2010.

STATEMEN	NT OF DEFICIENCIES	(X1) PRL JER/SUPPLIER/CLIA	(YO) 14	II TIDI C COMPTON		O. 0938-03
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUCTION DING		SURVEY
		445260	B. WIN	G	- 1	/20/2040
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, 2		/28/2010
BRIARC	CLIFF HEALTH CARE	CENTER		100 ELMHURST DR OAK RIDGE, TN 37830	OF CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE
F 502	Continued From pa	ge 8	F 50	02		
	nursing station and	pirector of Nursing, on October m., and 3:00 p.m., at the East lobby, confirmed the				
SS=D	January, April, July, interview confirmed results were not in the interview confirmed information to obtain Depakote level in Juconfirmed the facility as ordered by the pit 2010. 483.75(I)(1) RES RECORDS-COMPL LE The facility must man resident in accordant standards and practical accurately document systematically organists of the clinical record minformation to identify resident's assessment services provided; the preadmission screening and progress notes. This REQUIREMENT by: Based on medical receive, and interview, accurate and complete interview, accurate and accurate interview, a	ust contain sufficient of the resident; a record of the official the plan of care and e results of any ing conducted by the State; is not met as evidenced ord review, facility policy the facility failed to ensure e documentation in the official testing the policy the facility failed to ensure e documentation in the	F 51	F-514 Wound documentation for was updated to identify the measurements, and drainstype of drainage, amount any odors, status of the withe periwound tissue. Wound documentation for resident updated to reflect location, measurements and drainatype of drainage, amount cany odors, status of the work the periwound tissue. The Director of Nursing and Treatment Nurse reviewed with current wound care proposed in the content of the work of t	e location, age to include; of drainage, ound bed, or und t #12 was ge to include of drainage, ound bed, or d the all residents otocols and entified. s with eakly during e monitored Quality orised of the t. Medical	12-12-10
CMS-2567	(02-99) Previous Versions Ob-	soloto Event ID; B99311		Assurance.	If continuation shoot I	

	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SERVICES & MED D SERVICES					M APPROVED 0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION	(X3) DATE S	
		445260	B. WING		 	10/	28/2010
	PROVIDER OR SUPPLIER	CENTER	s	100 ELMH	RESS, CITY, STATE, ZIP C IURST DR GE, TN 37830		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION DESS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(XS) COMPLETION DATE
F 514	Continued From pa		F 51	1			
	Resident #12 was a March 5, 2009, and with diagnoses included by the March 5, 2009, and with diagnoses included by the Minimum Date 2010, revealed their Activities of Daily Livincontinent of bowel puree diet with thick impaired cognitively ulcer. Medical record reviet dated October 18, 2 had a Stage IV presimeasuring 1 cm (cer Continued medical in Treatment Record review dated "Stage IV 1 x 2 x 0.9 amount of drainage." revealed no docume drainage, any odors, the periwound tissue Resident #16 was ac September 24, 2010 Prostate Cancer, Collectum, Chronic Obstrutibia Fracture. Medidated October 1, 201	dmitted to the facility on readmitted on June 8, 2009, ading Hypertension, Sepsis, Alzheimers Disease, Chronic lindness, Cerebrovascular lonus. Medcial record review a Set (MDS) dated August 8, resident required total care for ving (ADLs), had been, had a Foley catheter, on a ened liquids, severely; and had a Stage III pressure of a Treatment Record 1010, revealed the resident sure ulcer on the right hip, intimeter) x 2.2 cm x 0.9 cm. ecord review of the evealed "Medium amount of m wound." Further medical October 25, 2010, revealed rt. (right) hip. Medium Medical record review intation of the type of status of the wound bed, or with diagnoses including					

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DEPARTMENT C		HAND HIMAN SERVICES			A mag 1	FORM	D: 11/02/2010 M APPROVED D: 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORRECT	ENCIES TION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		NSTRUCTION	(X3) DATE COMPI	SURVEY
		445260	B. WIN	G		10/	28/2010
NAME OF PROVIDER O		CENTER		100 ELM	DRESS, CITY, STATE, ZIP CODI HURST DR DGE, TN 37830		20/2010
PREFIX (EACI	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
with ADL	t of bowel,	ge 10 oley catheter in place, was and had no ulcers present on	F5	14			
Manager to foot let discovered 72-Hour "Brace has of foot - k redness of Medcial revealed wound clear physician revealed wound clear periwould or periwould or periwould ocument measured Review of Ulcer Previous of Medical redness of Medical Review of Medical redness of Medical Review of Me	dated Oct the grade of the grade on top of the control of the cord reviet to be cord reviet to be cord reviet to be cord reviet to continued in the facility rention of characteristics of the facility rention of characteristics of the cord the facility rention of characteristics of the facility rention of the fac	ew of a note by the Risk ober 13, 2010, revealed "Hip of left foot." Review of a coumentation form revealed blister to left foot - planter side in intact with no surrounding No drainage." Ew of a Treatment Record 010, revealed "2 cm x 2 cm left lateral 1 cm x 0.5 Stage Medical record review of a ted October 25, 2010, and (L) lateral ankle with only skin prep to periwound; an area only; secure with medical record review entation of any drainage from ppearance of the wound beds and imcomplete which ulcer is being cation. policy entitled "Pressure ide" revealed weekly aracteristics of normal skin f tissue deformation." ector of Nursing on October m., in the Administrator's documentation of the not complete regarding the ratus of the wound bed and					

CENTE	RS FOR MEDICAR	RE & MEL ID SERVICE	s			O. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER	A (X2) MUL	TIPLE CONSTRUCTION	(X3) DATE	
		445260	B. WING		_ 10	/28/2010
	PROVIDER OR SUPPLIER		Į.	STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELMHURST DR OAK RIDGE, TN 37830		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
		an a rae wagen		ļ. 		
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FORM APPROVED